EFR EMPLOYEE & FAMILY RESOURCES

Authorization to Disclose/Obtain Confidential Information for Treatment, Payment, and Healthcare Operations

I, _____, _____ , authorize Employee & Family Resources (EFR) to:
Client Name Date of Birth

☐ Disclose ☐ Obtain ☐ Disclose and obtain, written and verbal information with (select all that apply):

☑ My treating providers ☑ Third-party payers ☑ People helping to operate this program
☑ Health plans ☐ Others (specify): _____

Description of information to be disclosed/obtained (please initial next to each item to be disclosed/obtained):

_____ ☐ Assessment
_____ ☐ Diagnosis
_____ ☐ Treatment plan or summary
_____ ☐ Progress in treatment
_____ ☐ Presence/ participation in treatment
_____ ☐ Discharge/transfer summary
_____ ☐ Continuing care plan
_____ ☐ Demographic information
_____ ☐ Clinical notes
_____ ☐ Other (specify): _____

This authorization is for the purpose of (select yes/no for each item):

☐ Treatment ☐ Payment ☐ Healthcare Operations

Expiration (choose one): ☐ End of treatment ☐ Specific date (specify): _____
☐ No expiration ☐ Other (specify): _____

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying EFR in writing at the address provided on this form; the revocation will not apply to any information already released by EFR before receiving the revocation.
- Signing this authorization is not a condition of my treatment or payment for my services. However, I understand that if I refuse to authorize disclosure for the purpose of payment, I will be responsible for any associated expenses.
- Additional potential consequences for my refusal to sign this authorization, if applicable were explained to be:
  _____
- There is the potential that the protected health information (PHI) disclosed by EFR per this authorization may be redisclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations or 42CFR, Part 2 unless the recipient of the information is also obligated to and compliant with HIPAA and 42CFR, Part 2.

_____ _____
Signature of Client Date

_____ _____
Representative authorized to sign in lieu of client/Relationship to client Date

Notice of Redisclosure

To the extent substance abuse information has been released pursuant to this authorization, a copy of this authorization will accompany the disclosure and the recipient should note the following obligations: **42 CFR Part 2 prohibits unauthorized use or disclosure of these records.** This authorization permitted information to be disclosed to you from records protected by state and federal confidentiality rules. Federal law (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.